A Bipartisan Solution to Comprehensive Healthcare Reform:

- ***Improving Access***
- ***Controlling Costs***
- ***Enhancing Quality***

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VALUES FOR REFORM

IMPROVING ACCESS:

The lack of health insurance is a tragedy for those who do not receive the necessary preventative care and early intervention. Without access to care the health status of the uninsured is worse than their insured counterparts. Furthermore, the large number of uninsured places an unsustainable financial burden on California's health care system. With the 6.4 million uninsured Californians generally relying on emergency rooms and hospitals for their medical needs, the high cost of uncompensated care is crippling the entire healthcare system. Hospitals are closing; emergency rooms are diverting patients; and systems of care across the state are teetering on financial collapse.

Mandatory Coverage through Private Sector Health Plans:
To ensure all Californians have access to quality healthcare, the Universal Healthcare Act of 2005 will require every individual to at least maintain basic healthcare insurance, similar to mandatory auto insurance. Every Californian must at a minimum be covered by a high deductible health plan with medically indicated preventive care. Private sector health plans will provide these products which offer protection in the event of major medical problems or trauma, a primary issue for the largest group of uninsured aged between 18-34 (2.7 million or 42% of the uninsured population). Basic healthcare insurance will reduce the increasing trend of "medical bankruptcy," provide individuals with preventative care, and qualify them for network pricing established by the private sector health plan which reduces the cost of medical visits.

Purchasing Pools:
Newly established quasi-public purchasing pools, which will increase an individual and small businesses' buying power, will negotiate directly with insurance companies for a variety of benefit packages that can be offered in a cost efficient manner. Regardless of pre-existing medical conditions or risk, individuals will be guaranteed coverage through the purchasing pools at affordable prices with modified community rating.

These pools will offer a variety of benefits packages. They will range from catastrophic coverage with preventative care, to essential benefit plans that provide inpatient, out patient and pharmaceutical coverage. They may include enhanced benefit plans with comprehensive coverage, or even alternative medicine packages that include nontraditional styles of medicine. The pools will allow individuals and small businesses to enjoy the cost savings large groups and government agencies enjoy. Administrative, marketing and sales costs would dramatically be reduced.

The variety of products and flexibility will help make healthcare more affordable and further drive consumer's awareness of pricing and options. The purchasing pools would give individuals and small businesses the pricing advantages gained by large businesses and groups.

VALUES FOR REFORM

Voluntary Employer Partnership:
The Act would not impose any employer mandates, but would leverage dollars and make it much easier for small businesses and individuals to purchase affordable health insurance. A Qualified Employer Partnership Plan, created by the Managed Risk Medical Insurance Board and the Department of Managed Health Care, will assist small businesses with 50 or fewer employees, voluntarily participating in the partnership, in offering essential benefits insurance coverage for qualified low-income employees. The essential benefit plan would be a low-deductible plan which would include inpatient, out patient and pharmaceutical coverage. The program would provide federal and state subsidies through MediCal and Health Families, to the extent available, to encourage employers and workers to collaboratively gain access to high quality healthcare.

Streamlined Enrollment into Existing Programs:
To capture the currently eligible uninsured, the Cal-Health Act will simplify the enrollment process creating a streamlined, internet-based single point of entry for all health care programs offered by state and local government agencies. Currently, nearly 1.5 million uninsured children and parents (or 22% of the uninsured population) are eligible but not enrolled in these programs due to complicated and redundant processes.

Simplifying the complexity of eligibility rules, eliminating duplicative application procedures, and improving other program deficiencies will help eligible uninsured children and families obtain health insurance. Working with hospitals, clinics, schools, and others, Cal-Health will ensure that individuals and children already eligible for these programs enroll and receive benefits. Simplifying the process and removing barriers to entry, will allow California to take full advantage of federal matching funds to cover the cost of providing medical care to California's uninsured.

CONTROLLING COSTS:

Healthcare costs have been increasing at double digit, unsustainable rates. Last year, the average premium for a family of four was around $10,000. If rates continue to skyrocket at the current pace, these costs could reach $20,000 in the next five to six years. These high costs make healthcare coverage prohibitive for many Californians and contribute to the problem of the uninsured.

Pools and Flexibility:
Not only will the quasi-public purchasing pool, established in the Universal Healthcare Act of 2005, allow individuals and employers to gain greater purchasing power, but the pools will encourage innovation. The improved flexibility in benefit design will enable individuals to purchase products to address their needs, choose from a full range of options, and ultimately lower benefit costs.

Furthermore, the pools reduce administrative costs and eliminate middlemen. Administration, advertising and marketing costs will be slashed as the pools negotiate directly with health plans.

VALUES FOR REFORM

Cost Awareness:
Additional costs savings rely on simply making individual consumers more aware of the costs and pricing of services. Similar to how the laser surgery for vision correction has become more affordable and available to consumers, the Act improves an individual's cost awareness by allowing them to make choices about when and where they wish to receive services.

Eliminating the Uninsured Cost Shift:
The Universal Healthcare Act will also eliminate the cost shift and hidden tax in the current healthcare system that supports the services provided to the 6.4 million uninsured. With the individual mandate and other coverage provisions, the current cost shift to private premiums to cover the uncompensated costs of the uninsured will be largely eliminated, reducing costs pressures on the entire system.

MediCal Prescription Drugs:
To reduce the costs of prescription drugs in MediCal, the Prescription Drug Consumer Protection Act will require that only generic drugs be used unless it can be demonstrated that the drug will lead to patient outcomes that are better those of the generic drug used for the same condition.

Electronic Medical Records:
The Patient Safety and Information Technology Act, moving to implement electronic medical records across the entire industry, will realize billions of dollars of savings.

Evidence Based Guidelines and Best Practices:
The Center for Quality Medicine will develop medical care guidelines based on scientific evidence and help establish appropriate care. The evidence based guidelines will establish best practices which will ultimately control costs, improve quality, and reduce the overuse and underuse of services.

Seismically Retrofitting Hospitals:
Focusing on the development of affordable, high quality healthcare, the seismic retrofit requirements which hospitals are required to meet by 2008 and 2013 will be modified. These retrofit costs have been estimated to exceed $40 billion.

ENHANCING QUALITY:

Enhancing quality while improving access and controlling costs is paramount to reforming the healthcare system.

The Center for Quality Care:
To attain the goal of efficient, high quality care, the Center for Quality Care Act will establish a Center for Quality Care research institute. Recognizing the importance of collection and analysis

of medical data, the Center will collect and research treatment data and develop evidence based guidelines and best practices, ultimately improving the quality of healthcare in California. With guidelines based on medical and scientific evidence, the Center will address issues like overuse and underuse, and establish guidelines for appropriate care. It will also make recommendations for benefit design, evaluate cost effectiveness for new technologies and pharmaceuticals, identify quality measurements, and standardize quality reporting.

Modernizing with Information Technology:
Modernizing and implementing new information technologies will reduce medical errors and save lives. The Patient Safety and Information Technology Act will implement an electronic medical records system throughout the industry including hospitals, insurers, health plans, and medical providers. The electronic medical records system will ensure that healthcare professionals have timely access to important patient medical information. Furthermore, efficient record keeping will improve treatment outcomes creating a foundation for the development of evidence based medicine, best practices and continuous quality improvement.

Advanced Directives and Terminal Illness Decisions:
Regardless of age, it is important for all Californian's to be informed about end of life issues. This legislation will broaden awareness of issues related to terminal illness and other end of life decisions pertaining to medical care. An emphasis will be placed on educating individuals and families about advanced health directives and other choices and alternatives relating to end of life care. The Department of Health Service along with the Department of Motor Vehicles will distribute the material and help educate individuals, families and healthcare providers about important alternatives for end of life care. The information will be available and easily accessed through the web.

CALIFORNIA'S CRUMBLING HEALTHCARE SYSTEM: THE UNINSURED

UNINSURED BY AGE GROUP

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2004 Supplement

Age Group	# of Uninsured	Percent of Total
0-17	1,195,949	18.6%
18-34	2,728,729	42.4%
35-44	1,182,270	18.3%
45-54	876,482	13.6%
55-64	459,679	7.1%
Total	**6,443,110**	**100%**

- ***6.4 million People in California are Uninsured.***
- ***Over 40% of Uninsured are Between 18-34.***

THE UNINSURED: FEDERAL POVERTY LEVEL

UNINSURED BY INCOME LEVEL AS A PERCENT OF THE FPL

FPL stands for Federal Poverty Level. FPL in 2003 was $8,980 for a single person and $18,400 for a family of four. 200% FPL $17,960 for a single person and $36,800 for a family of four.

Source: 2004 Current Population Survey / UCLA Center for Health Policy Research

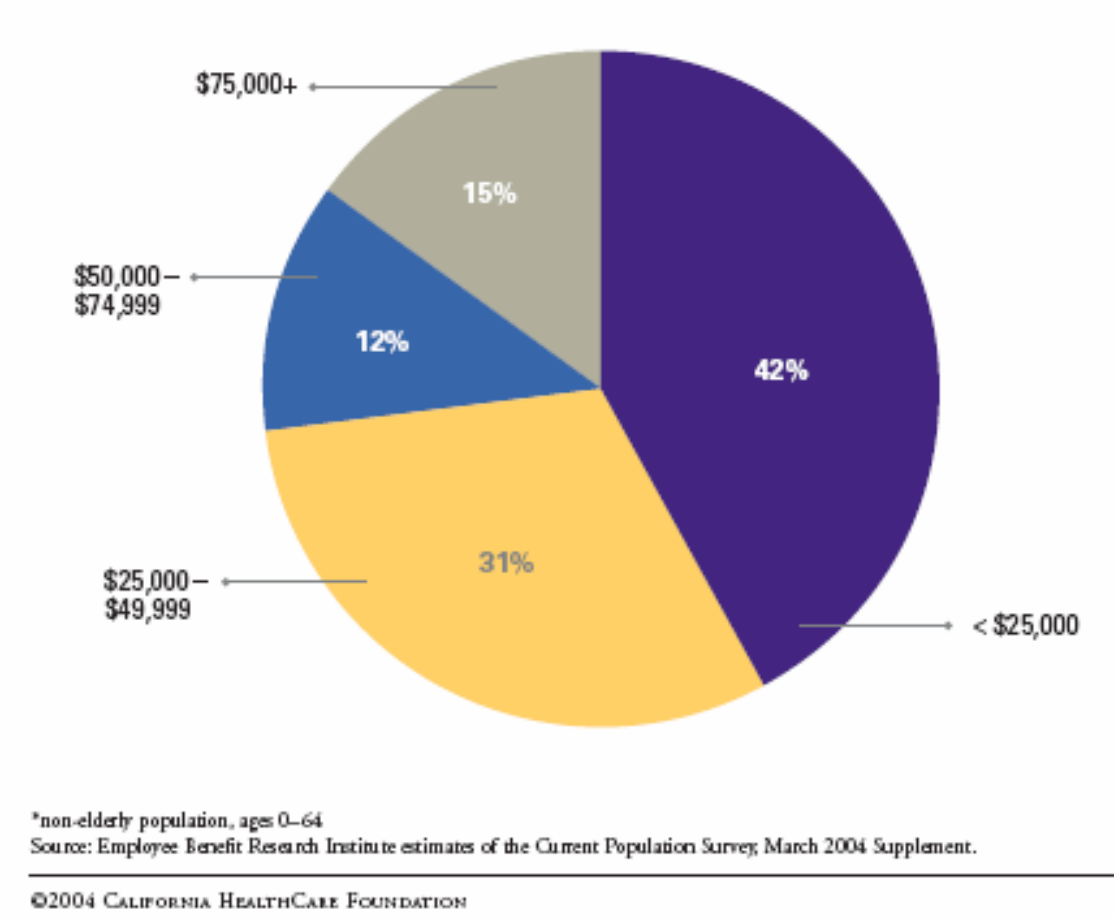
Income % of FPL	Ages 0-17 (%)	18-34 (%)	35-44 (%)	45-54 (%)	55-64 (%)
< 50% FPL	137,000 (11.6)	291,000 (10.7)	122,000 (10.4)	81,000 (9.3)	*
50-99%	172,000 (14.5)	278,000 (10.2)	163,000 (13.8)	75,000 (8.6)	*
100-149%	243,000 (20.5)	477,000 (17.6)	232,000 (19.8)	143,000 (16.4)	152,000* (33.2)*
150-199%	200,000 (16.8)	414,000 (15.3)	138,000 (11.7)	103,000 (11.8)	**
200-299%	192,000 (16.1)	544,000 (20.0)	188,000 (16.0)	151,000 (17.3)	125,000** (27.3)**
300-399%	120,000 (10.1)	275,000 (10.1)	125,000 (10.6)	119,000 (13.6)	77,000 (16.8)
400% +	125,000 (10.5)	438,000 (16.1)	209,000 (17.7)	201,000 (23.1)	105,000 (22.8)

** Sample size for individual cells are too small to report. Estimate is for all income levels up to 149% FPL.*
*** Sample size for individual cells are too small to report. Estimate is for all income levels up to 299% FPL.*
Note: UCLA rounded its figures so numbers may not equal same EBRI uninsured estimates from previous slide

THE UNINSURED: HOUSEHOLD INCOME

FAMILY INCOME OF THE UNINSURED

Source: California HealthCare Foundation / ERIB estimates of the Current Population Survey, March 2004 Supplement



*non-elderly population, ages 0–64
Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2004 Supplement.

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THE UNINSURED: PUBLIC PROGRAM ELIGIBILITY

UNINSURED THAT ARE ELIGIBLE BUT NOT ENROLLED IN MEDI-CAL AND HEALTHY FAMILIES

Source: California HealthCare Foundation / ERIB estimates of the Current Population Survey, March 2004 Supplement

Children Eligible for Healthy Families	**10%** ***644,311 children***
Children Eligible for Medi-Cal	**6%** ***386,587 children***
Parent Eligible for Medi-Cal	**7%** ***451,018 parents***
Not Eligible for Medi-Cal or Healthy Families	**76%** ***4,896,763 people***

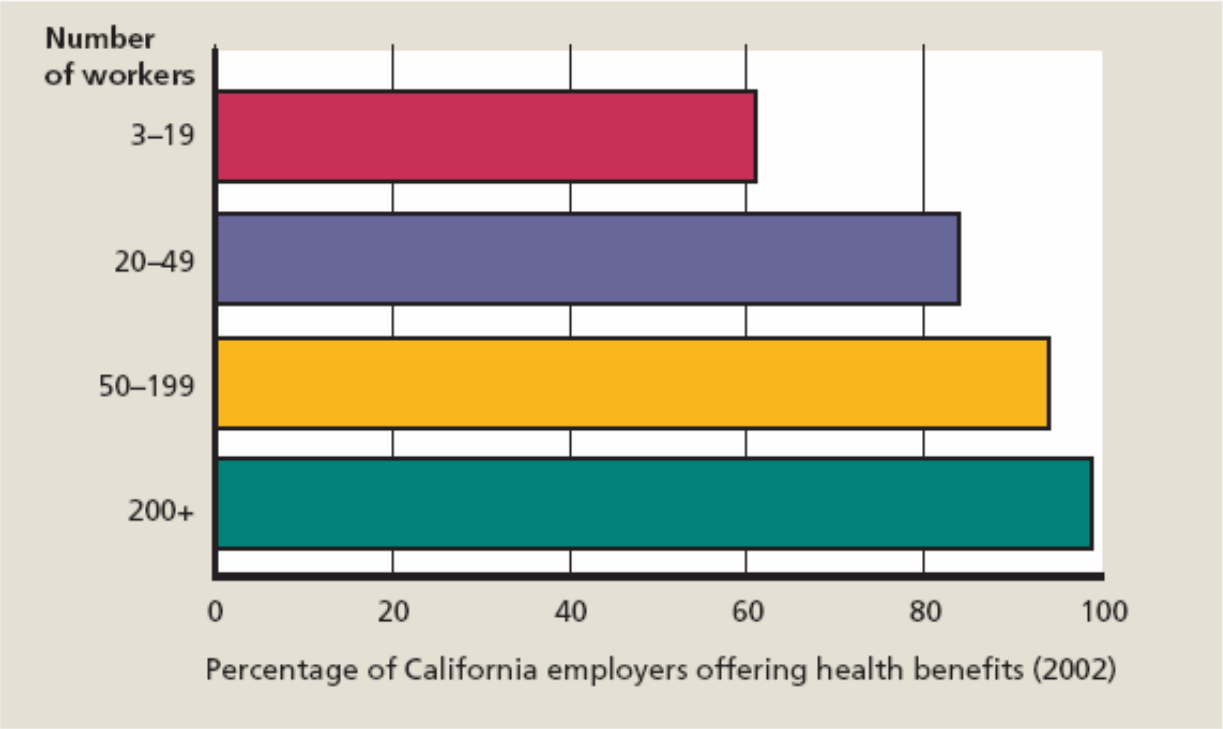
Table includes non-elderly population, ages 0-64
Note: The uninsured may be eligible for other public programs

THE UNINSURED: EMPLOYER COVERAGE BY SIZE

PERCENT OF EMPLOYERS PROVIDING HEALTHCARE TO EMPLOYEES

Source: Rand Health Presentation – Health Care in California: A Policy Assessment

Source: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, 2003b.

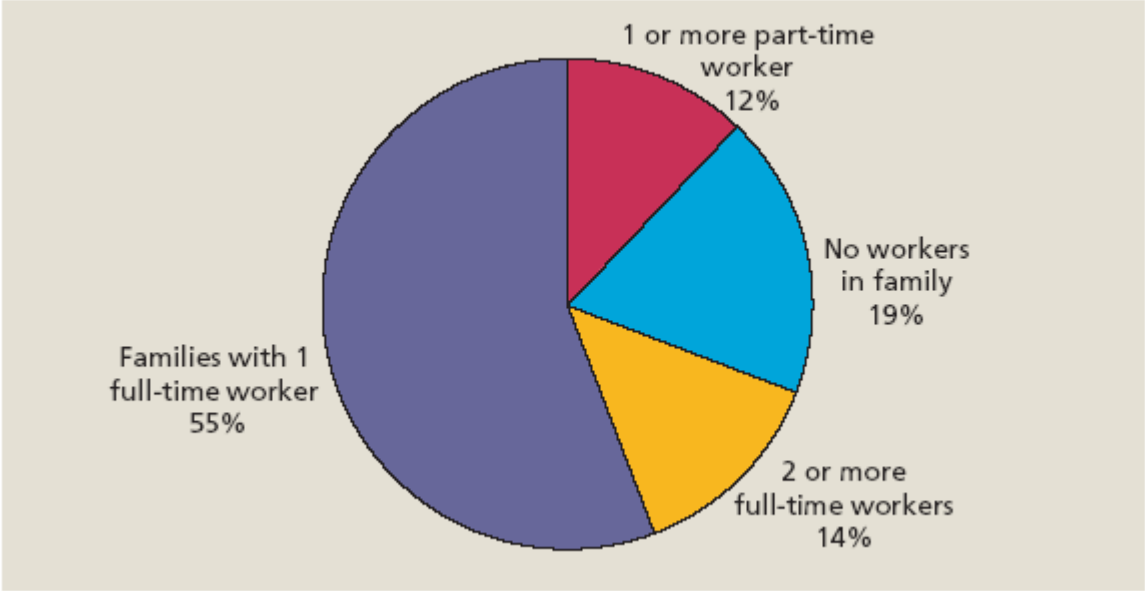


THE UNINSURED: EMPLOYMENT

MOST UNINSURED LIVE IN FAMILIES WITH AT LEAST ONE WORKER

Source: Rand Health Presentation – Health Care in California: A Policy Assessment

Source: Kaiser Commission on Medicaid and the Uninsured, 2003a.

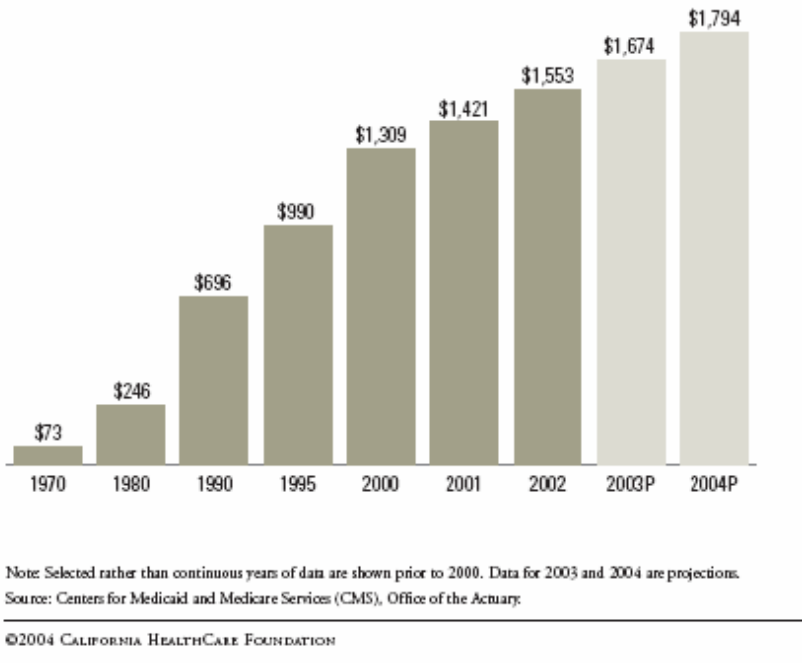


- In 2002, 70 percent of the uninsured lived in a family with at least one full-time worker
- Fewer than 20 percent lived in families where no one works

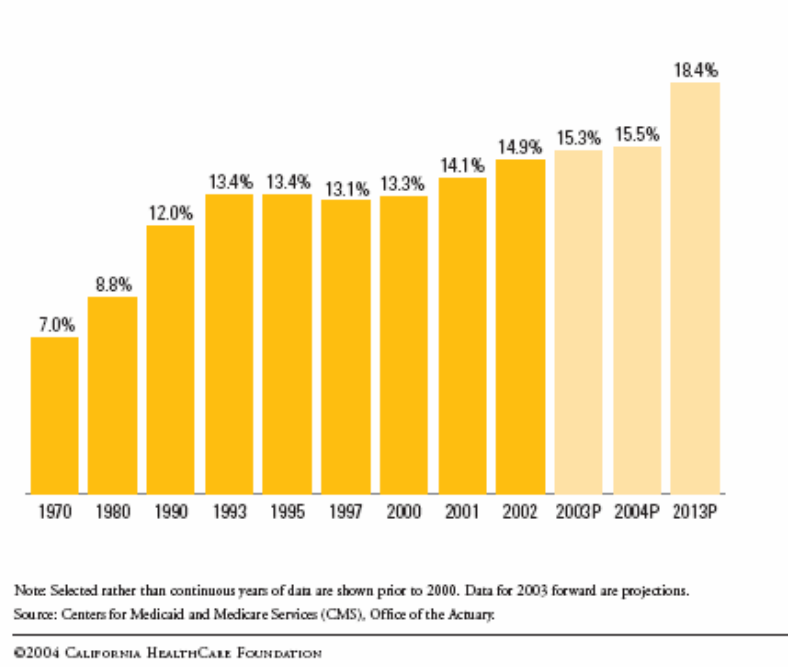
CALIFORNIA'S CRUMBLING HEALTHCARE SYSTEM: INCREASING COSTS: TOTAL SPENDING

NATIONAL HEALTHCARE SPENDING IN DOLLARS AND % OF GDP

Source: California HealthCare Foundation



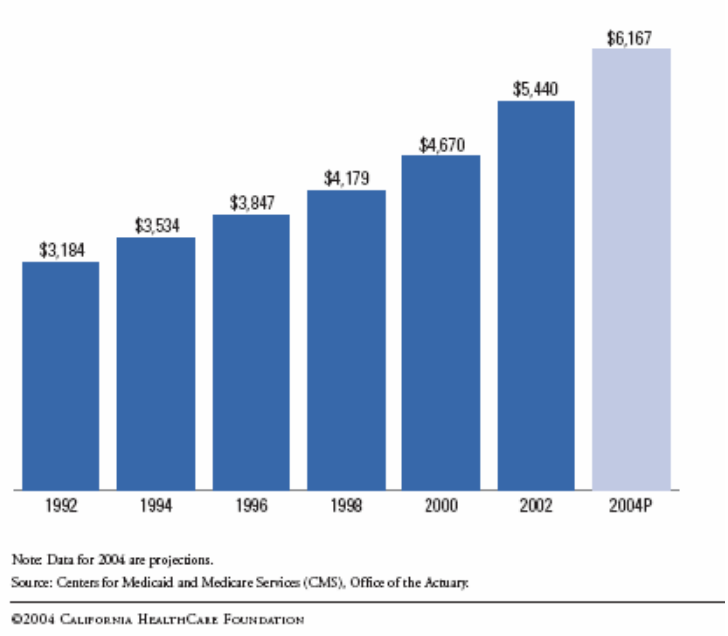
Note: Dollars in Billions



INCREASING COSTS: SPENDING OVERVIEW

NATIONAL HEALTH SPENDING PER PERSON AND BY SPENDING DISTRIBUTION

Source: California HealthCare Foundation



Note: Data for 2004 are projections.
Source: Centers for Medicaid and Medicare Services (CMS), Office of the Actuary.

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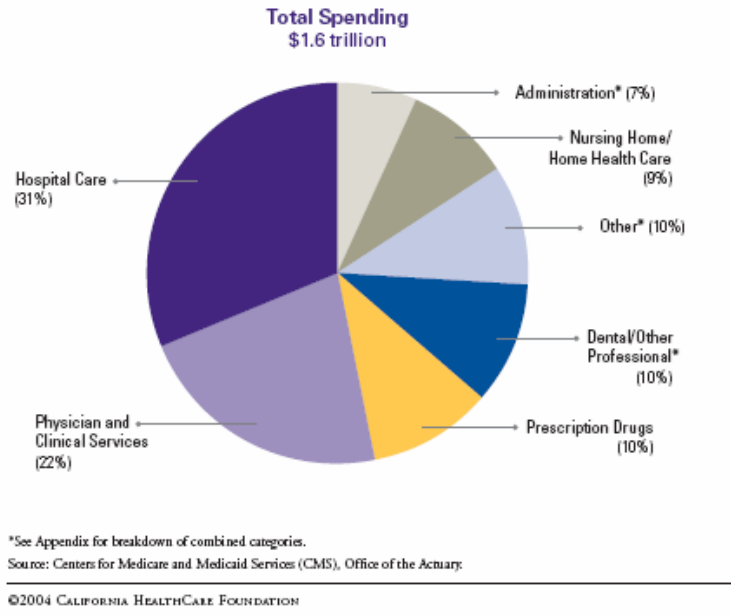

*See Appendix for breakdown of combined categories.
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

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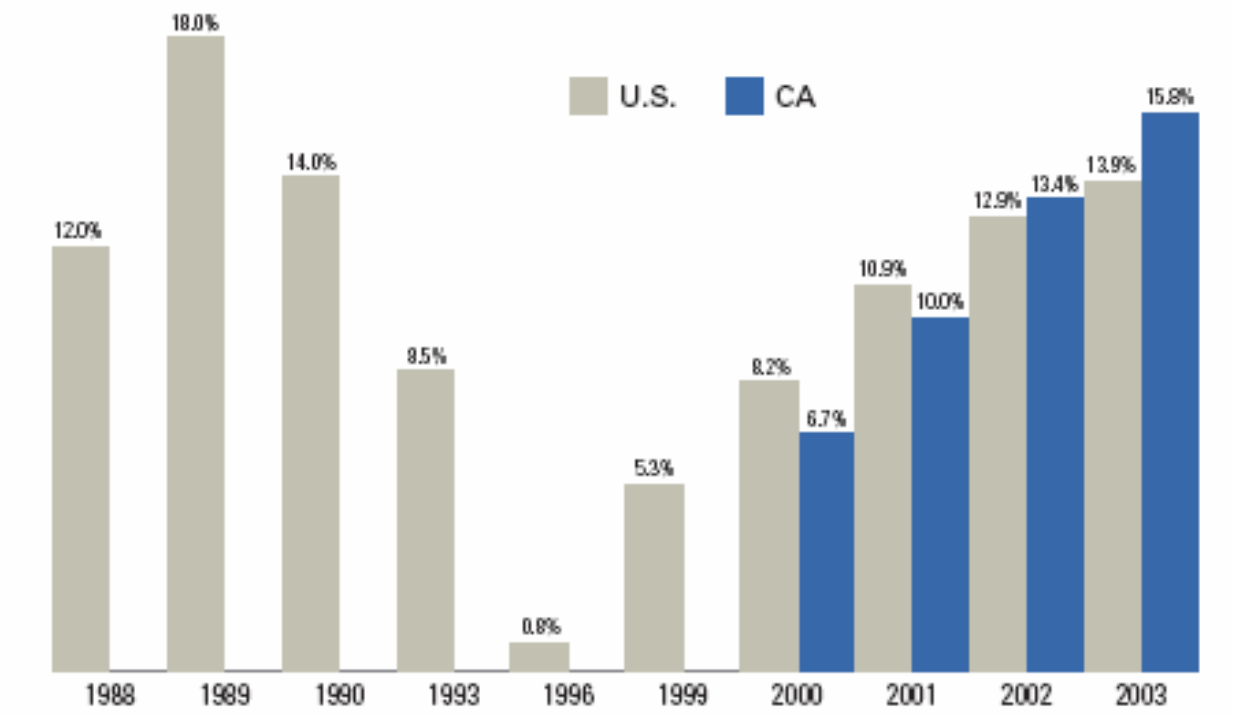
INCREASING COSTS: PREMIUMS SOAR

ANNUAL GROWTH IN PRIVATE HEALTH PREMIUMS

Source: California HealthCare Foundation



Notes: Data on premium increases reflect the cost of employer-based health insurance coverage for a family of four. Percent increase represents the growth over the immediate prior year. Selected rather than continuous years of data are shown prior to 1999.

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 2003. California survey not conducted prior to 2000.

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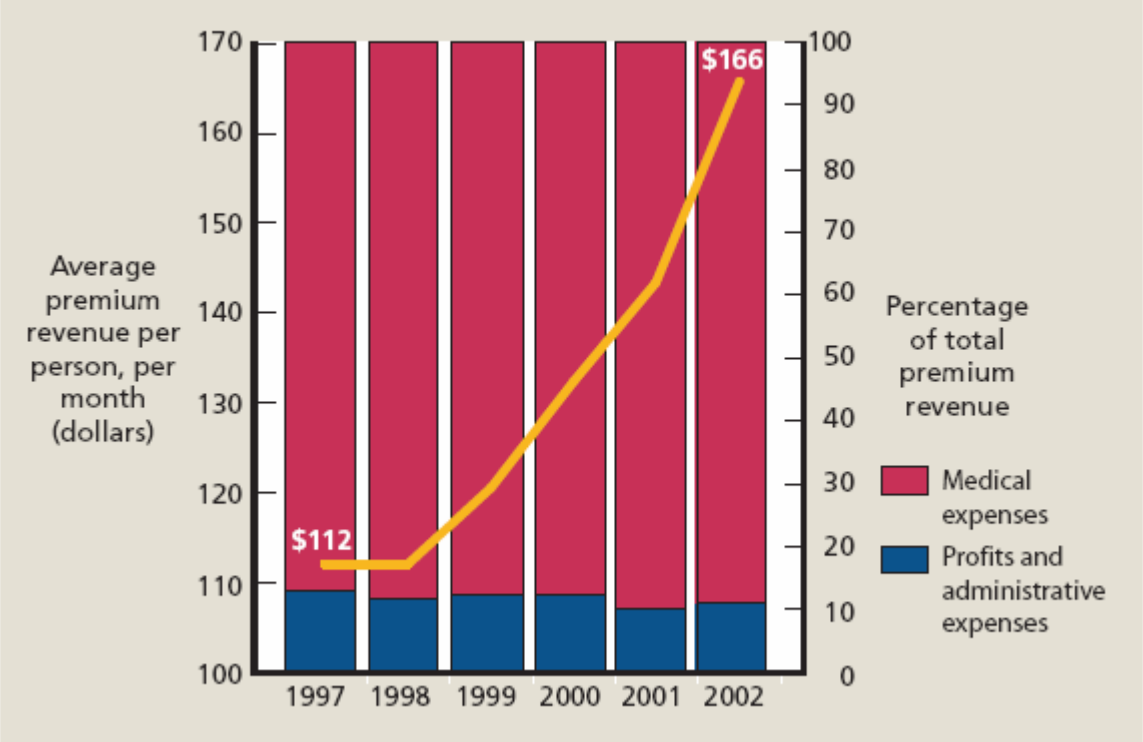
INCREASING COSTS: PROFITS REMAIN STEADY

PREMIUMS INCREASE WHILE PROFITS REMAIN STEADY

Source: Rand Health Presentation – Healthcare in California: Costs and Insurance

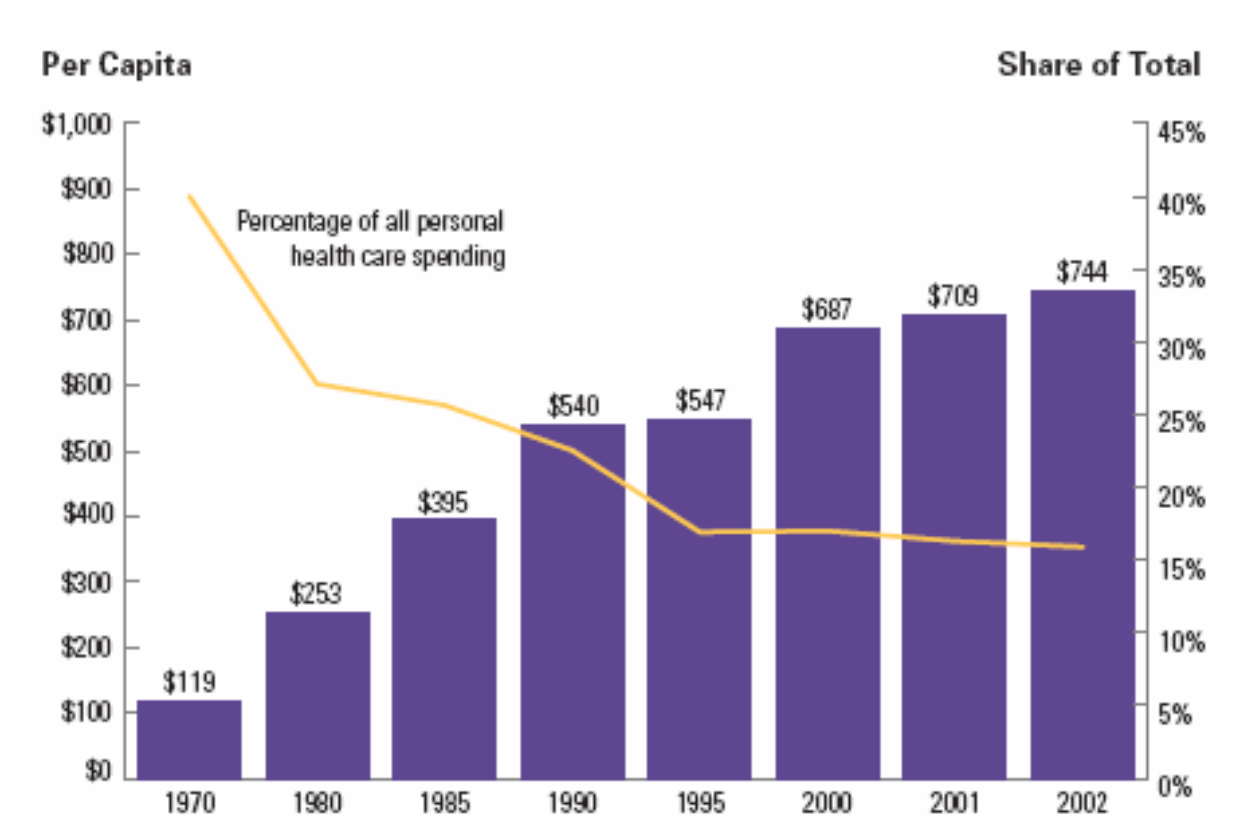
Source: Baumgarten, 2004.



INCREASING COSTS: EMPLOYEE SHARE OF COSTS

ANNUAL OUT-OF-POCKET SPENDING

Source: California HealthCare Foundation



Notes: Selected rather than continuous years of data are shown prior to 2000. Out-of-pocket spending includes direct spending by consumers for all health care goods and services, such as coinsurance, deductibles, and any amounts not covered by insurance. Out-of-pocket premiums paid by individuals are not counted here but are counted as part of private health insurance.

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

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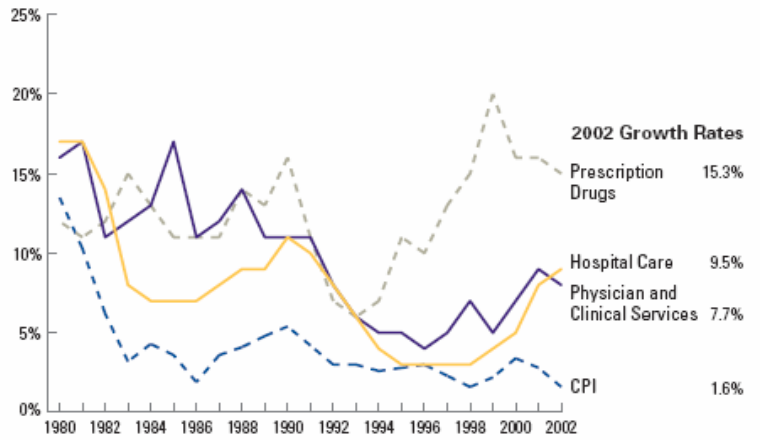
CALIFORNIA'S CRUMBLING HEALTHCARE SYSTEM: COST PRESSURES: PRESCRIPTION DRUGS

PRESCRIPTION DRUGS ARE A RISING SHARE OF EXPENDITURES

Source: California HealthCare Foundation

Average Annual Growth Rates
by Health Spending Categories



Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

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Category	Spending Levels (billions) 1982	2001	2002	Spending Distribution 1982	2001	2002	Growth ('02 over '01) Billions	Percentage
NATIONAL HEALTH EXPENDITURES (NHE)	$321	$1,421	$1,553	100%	100%	100%	$132	9%
Hospital Care	135	444	487	42%	31%	31%	42	9%
Physician and Clinical Services	61	315	340	19%	22%	22%	24	8%
Dental/Other Professional*	26	149	162	8%	10%	10%	13	9%
Nursing Home/ Home Health Care	26	133	139	8%	9%	9%	6	5%
Prescription Drugs	15	141	162	5%	10%	10%	22	15%
Administration†	17	90	105	5%	6%	7%	15	16%
Other**	41	148	158	13%	10%	10%	10	7%

* "Dental/Other Professional" includes other professional, dental, and other personal health care (see Appendix).
† "Administration" refers to government program administration (spending for the cost of running various government health care programs) and net cost of private health insurance (the difference between premiums earned by insurers and the claims or losses incurred for which insurers become liable).
** "Other" includes durable medical equipment, other non-durables, government public health activities, and research and construction (see Appendix).

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

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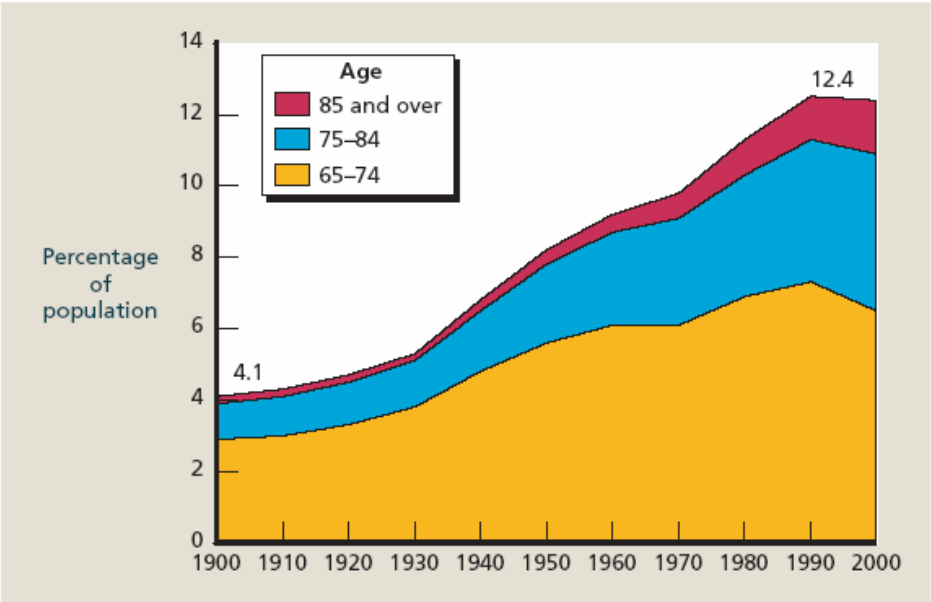
COST PRESSURES: ELDERLY

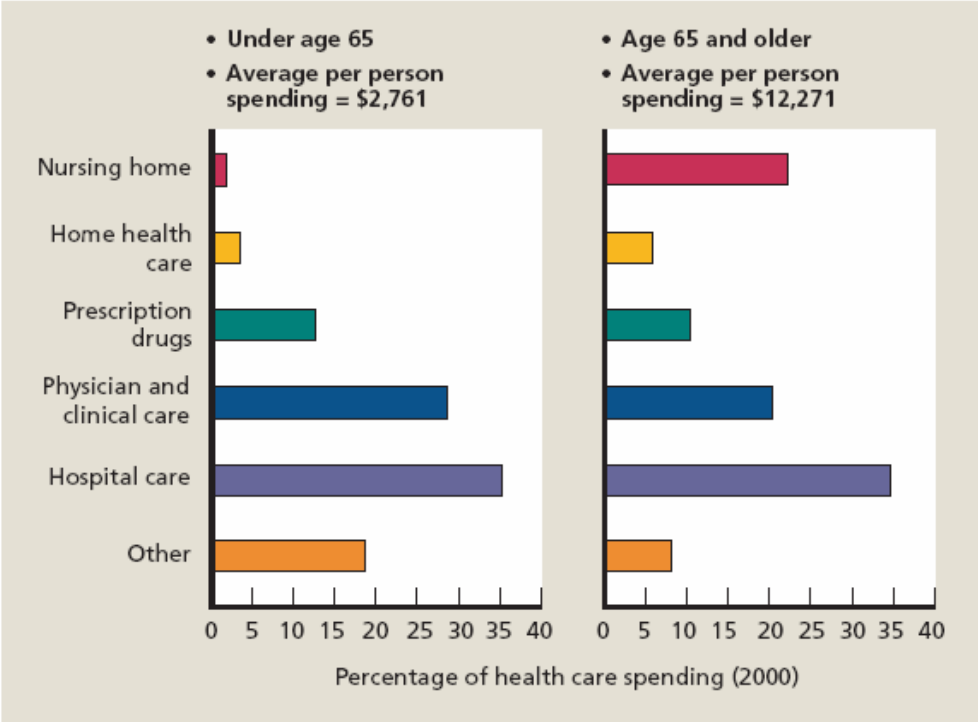
ELDERLY POPULATION INCREASING AS COSTS RISE

Source: Rand Health Presentation – Healthcare in California: Costs and Insurance

Source: Hobbs and Stoops, 2002.



Source: Meara, White, and Cutler, 2004, Exhibit 4.



CALIFORNIA'S CRUMBLING HEALTHCARE SYSTEM: QUALITY: STRIVING TO PROVIDE THE HIGH QUALITY CARE

UNDERSTANDING QUALITY

Source: Rand Health Presentation – Healthcare in California: Quality of Care

Source: Institute of Medicine, 2001.

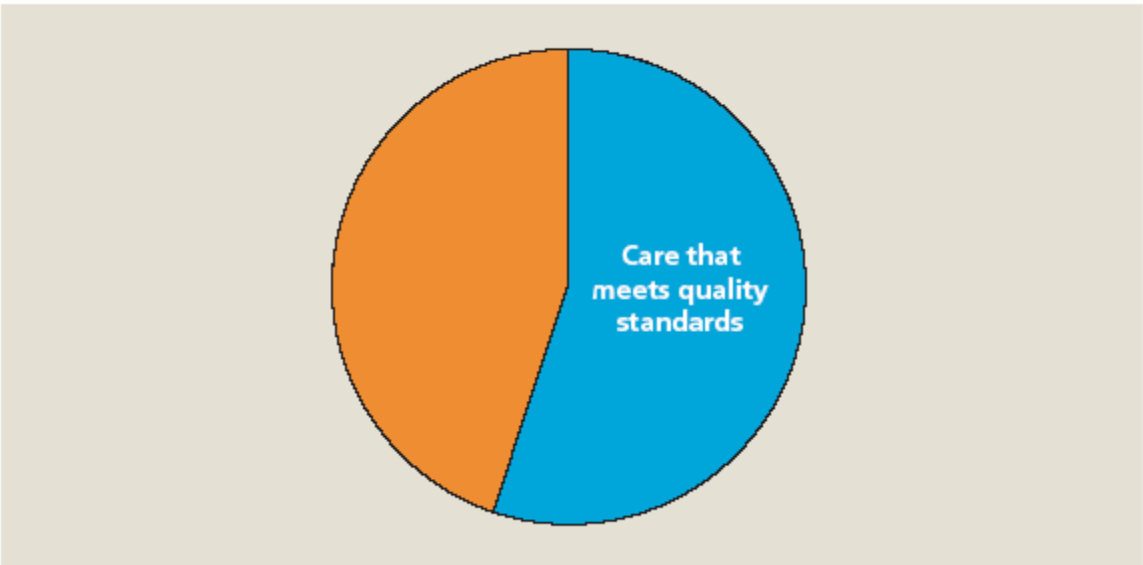
Elements of quality care		Type of quality problem
People get the care they need	Effectiveness	Underuse
People need the care the get		Overuse
Provided safely		Error
Timely		Delays
Patient centered		Unresponsive
Delivered equitably		Disparities
Delivered efficiently		Waste

QUALITY: CARE NOT ALWAYS RECEIVED

RECOMMENDED CARE

Source: Rand Health Presentation – Healthcare in California: Quality of Care

Source: McGlynn et al., 2003.



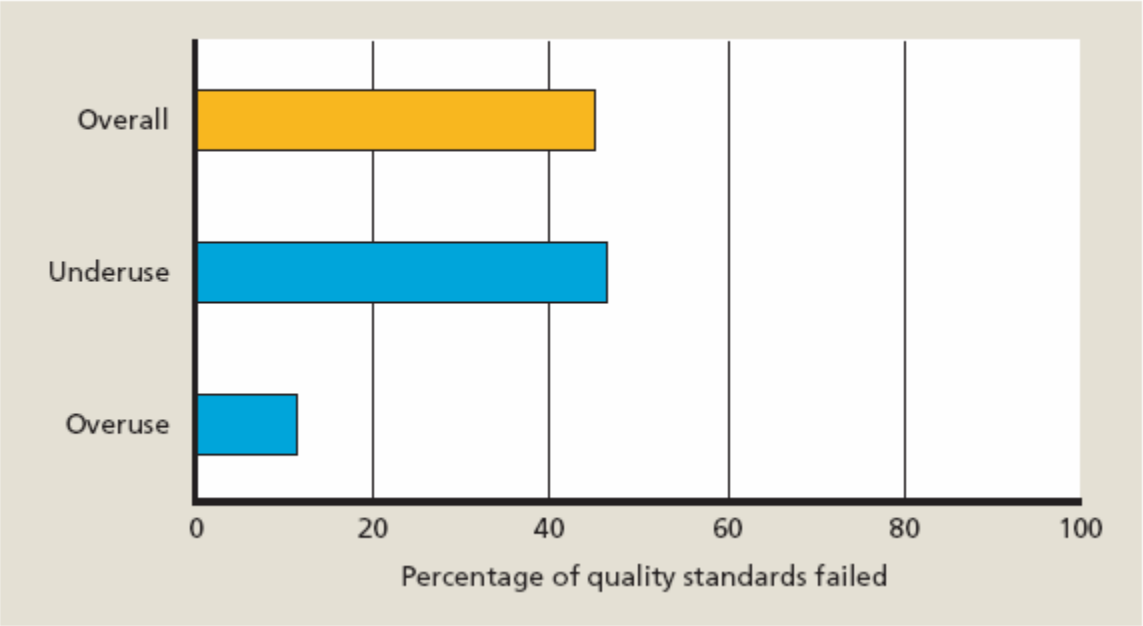
- In the only national study conducted on quality of care, RAND found that American adults were receiving about one-half of recommended medical services—that is, services shown in the scientific literature to be effective in specific circumstances and agreed upon by medical experts
- This study used RAND's Quality Assessment (QA) Tools system, a comprehensive method for assessing quality that includes 439 measures of effectiveness for 30 acute and chronic health problems of adults as well as the leading preventive health care interventions

QUALITY: UNDERUSE A PROBLEM

UNDERUSE CAN BE A GREATER PROBLEM THAN OVERUSE

Source: Rand Health Presentation – Healthcare in California: Quality of Care

Source: McGlynn et al., 2003.



- RAND's national study found that failure to deliver needed services (underuse) occurred more often than delivering services that were not needed or harmful (overuse)
- Patients failed to receive needed services 46 percent of the time
- Patients received services they did not need 11 percent of the time. This rate of overuse is consistent with previous findings about the rates of use for surgical procedures that were clearly inappropriate but may underrepresent the total rates of overuse in the population

QUALITY: NEED FOR IMPROVEMENT

CONSEQUENCES OF POOR QUALITY

Source: Rand Health Presentation – Healthcare in California: Quality of Care

Condition	What we found	Estimated preventable complications/deaths (annual)
Diabetes	Blood sugar not measured for 40%; 24% uncontrolled	2,500 blind; 29,000 kidney failure
Hypertension	Blood pressure uncontrolled in 58%	68,000 deaths
Heart attack	39–55% did not receive needed medications	37,000 deaths
Pneumonia	36% no vaccine	10,000 deaths
Colon cancer	62% not screened	9,600 deaths

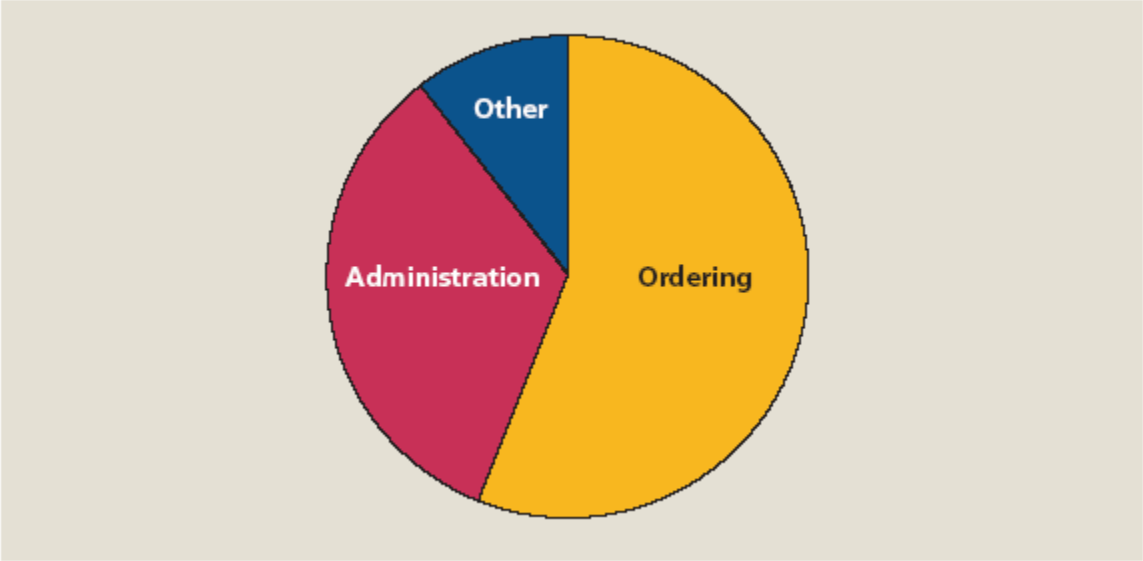
- Patients with hypertension received less than 65 percent of recommended care. Uncontrolled blood pressure is associated with increased risk for heart disease and stroke and has been estimated to cause 68,000 preventable deaths annually (Woolf, 1999)
- People with coronary artery disease received 68 percent of recommended care, but just 45 percent of heart attack patients received beta blockers and 61 percent got aspirin. This gap has been estimated to cause 37,000 preventable deaths annually (Woolf, 1999)
- Fewer than two-thirds of elderly Americans were vaccinated against pneumonia. Nearly 10,000 deaths from pneumonia could be prevented annually through proper vaccinations (Woolf, 1999)
- Just 38 percent of adults over age 50 were screened for colorectal cancer. Routine tests and appropriate follow-up could prevent 9,600 deaths a year (Woolf, 1999)

QUALITY: PREVENTABLE MISTAKES

ORDERING AND ADMINISTERING DRUGS SIGNIFICANT PROBLEM

Source: Rand Health Presentation – Healthcare in California: Quality of Care

Source: Bates et al., 1995.



- A study of the sources of preventable adverse drug events found that 56 percent occurred at the time a medication was ordered and 34 percent when the drug was administered
- Errors were more likely to be intercepted by computerized systems if they occurred earlier in the process (48 percent of ordering errors were preventable compared to 0 percent of administration errors)

HOSPITALS AND ER'S CLOSING AT ALARMING RATES

CALIFORNIA HOSPITALS AND EMERGENCY ROOMS CLOSURES

Source: California Healthcare Association

- ***82 California Hospitals Closed Between 1996 -- 2004***

- ***Closures and Changes in 2004:***

  - 8 Hospitals Closed

  - 2 Trauma Centers Closed

  - 6 Emergency Departments (ED) Closed

  - More than 10 EDs downsized or downgraded

  - More than 50 hospitals closed or downsized a department of unit

- ***Average Operating Margins for California Hospitals***

	1993	2003	Change
Expenses Per Day	$1,610.91	$2,485.90	54%
Patient Revenue Per Day	$1,630,96	$2,366.60	45%

- ***51% of Hospitals in 2003 had Negative Operating Margins***

SEISMIC RETROFITS: FUNDING THE MANDATE

COSTS TO MEET HOSPITAL SEISMIC SAFETY MANDATE

Source: California Healthcare Association

- CHA conservatively estimates that the hard construction cost for meeting the hospital seismic safety mandate will be at least $40 billion without financing charges.

- RAND has placed the price tag as high as $41 billion without financing costs.

- Many hospitals are not credit worthy and cannot qualify for a loan to make their retrofit or rebuilding projects feasible.

- "The real irony is that unless access to capital is made available or the implementation deadlines are altered, the law intended to keep hospitals open following a major earthquake may instead force some hospitals to close before the next earthquake occurs." *-- Duane Dauner, President of the California Hospital Association.*

UNIVERSAL HEALTHCARE ACT OF 2005

Individual Mandate

- Require every individual to, at a minimum, maintain basic health care insurance.
- Minimum coverage is defined as any plan regulated by either the DMHC or DOI that contains a maximum annual deductible of $5,000 per person and provides first dollar coverage for all medically indicated preventative care.

Establishment of a Quasi-Public Purchasing Pool

- The Secretary of the Health and Human Services Agency shall work with each county to establish a public/private purchasing pool for the purpose of obtaining insurance for all individuals who do not have coverage by another means. Counties at their discretion may join with other counties to operate a regional purchasing pool.
- Individuals and employers may purchase insurance through a purchasing pool to take advantage of coverage options and pricing available through the purchasing pool. The purchasing pool shall negotiate with insurance companies for a range of insurance products, including catastrophic with medically indicated preventative care, an essential benefits package and any other medical services that can be offered in a cost efficient manner. An essential benefit plan will provide inpatient, out patient and pharmaceutical coverage.
- Insurance companies and health plans that participate in the purchasing pool shall guarantee issue of coverage to all applicants and provide rates on a modified community rating basis. Any health plan participating in a purchasing pool must offer an essential benefit plan in addition to a high deductible catastrophic plan, which must include coverage for medically indicated preventative care.
- Managed Risk Medical Insurance Board and the Department of Managed Health Care shall identify the benefits needed for an essential benefits package for use by the purchasing pools that will be less expensive than the current market products, but still provide basic coverage under a delegated risk model.

Qualified Employer Partnership Plan

- The Managed Risk Medical Insurance Board and the Department of Managed Health Care shall establish a voluntary, non-entitlement program that would give available state and federal money to subsidize qualified employers who offer essential benefits insurance coverage for employees whose family earnings are less than 200% of federal poverty level. An essential benefit plan will be a low-deductible plan which includes inpatient, out patient and pharmaceutical coverage.
- A qualified employer is one that has less than 50 employees and 60% of those employees earn less than 200% of minimum wage. Any available federal funds would be used at the allowed match rate and any state-only match shall be 50-50. Crowd out provisions shall

UNIVERSAL HEALTHCARE ACT OF 2005 CONTINUED

- prohibit participation in the plan if the employer has offered insurance within the last 12 months. MRMIB and DMHC will develop additional crowd out criteria.

Enforcement

- As part of their annual tax filing, each taxpayer will be required to submit proof of coverage to the Franchise Tax Board for themselves and any dependents claimed, unless the taxpayer's employer reports the proof of coverage for the employee and any dependent through the employers regular payroll report to the Employment Development Department.
- Any individual who does not provide evidence of insurance for themselves and any dependents shall have an amount withheld from their taxes equal to the annual cost of providing minimum required coverage provided by their county's purchasing pool. The Franchise Tax Board shall transmit those sums to the respective purchasing pool on behalf of that taxpayer and their dependents.

Funding

- The current gross premiums tax, currently paid by all insurance companies, shall be applied to all health plans regulated by the Department of Managed Health Care, creating a health access fee that will be deposited into a dedicated fund for use as matching funds for government sponsored health care only. An equivalent tax would be levied on those who administer healthcare programs for large, self-insured businesses.
- The deductibility of health insurance premium costs from state income taxes will be capped at a level that reflects the essential benefits package provided through the purchasing pools.
- The special funds shall first be used as matching payments for children enrolled under this bill, then parents of children enrolled in the Healthy Families Program, and then remaining funds shall be available for subsidies allowed in the Employee Partnership Program.

AN INTEGRATED APPROACH TO HEALTHCARE REFORM

CAL-HEALTH ACT

Streamlined Enrollment into Public Healthcare Programs

- The Department of Health Services shall establish an enrollment and retention program known as Cal Health. This program shall be a single point of entry for all health care programs offered by state and local government agencies.
- The department shall use to the maximum extent possible an electronic enrollment process such as the Health-E-App and may contract for private technology, enrollment and retention services.
- The department may use any state data bases to identify and locate individuals that may be eligible, but not enrolled in health care programs. This data base may be integrated with other government data bases to advance the purpose of expanding enrollment.

PATIENT SAFETY AND INFORMATION TECHNOLOGY ACT

Electronic Medical Records

- Hospitals, insurers, and health plans shall have electronic medical records systems in place no later than 2010.
- Medical providers shall have EMR systems in place no later than 2012.

Standards and Confidentiality

- The Department of Managed Health Care will develop standards, no later than 2007, in order to ensure uniformity of the interoperability, Internet access, content and design of electronic medical records.
- Patients shall not at any time be denied access to their individual record by any hospital, insurer, health plan, or medical provider.
- System must conform to federal and state guidelines for confidentiality.

Funding

- The California Patient Safety and Information Technology Infrastructure fund is hereby established for the purpose of providing low-interest loans, interest rate assistance and credit enhancements to hospitals, insurers, health plans, and medical providers complying with the requirement to develop electronic medical records.
- Providers who fully implement electronic medical records shall be eligible for a yet to be determined percent increase in Medi-Cal provider rates.

CENTER FOR QUALITY MEDICINE ACT

Center for Quality Medicine

- The Department of Managed Health Care shall contract with an academic institution or public policy research institution for the establishment of a Center for Quality Medicine.
- The Center for Quality Medicine shall include a board of directors to oversee the Center and advance its mission.
- The Center for Quality Medicine will conduct periodic research regarding the medical treatment data. The research shall include, but not be limited to, development of evidence based guidelines, recommendations for benefit design, evaluation of cost effectiveness for new technologies and pharmaceuticals, quality measurements by providers and health plans and standardize quality reporting. The Center shall widely disseminate its findings, including a database of quality measurements.
- The Department of Managed Health Care shall utilize the Center for Quality Medicine's findings in regulating health care providers and health plans.

Funding

- Funding for the Center for Quality Medicine shall be $25 million annually, taken from the Gross Premiums taxes paid by health insurance companies and health plans.

ADVANCE DIRECTIVES & TERMINAL ILLNESS EDUCATION

Advanced Health Care Directives

- The Department of Health Services shall develop and Department of Motor Vehicles shall include information about end of life care, decisions relating to terminal illness, and advanced health care directives as part of its regular vehicle registration mailings.
- The Department shall also display information regarding advanced health care directives at Department field office. The information will also be available on the web.
- The State Registry of Advanced Health Care Directives shall be linked with the electronic medical records systems of hospitals and medical providers.

MEDICAL PRESCRIPTION DRUG CONSUMER PROTECTION ACT

Use of Generic Prescription Drugs

- Any drug other than a generic drug shall not be included on the Medi-Cal formulary unless it can be demonstrated that the drug will lead to patient outcomes that are better than the outcomes achieved with generic drugs for the same condition. Findings by the Center for Quality Medicine shall be presumed to be correct in making formulary decisions.

- Any drug that is not included on the Medi-Cal formulary may be obtained through the TAR process.
- Guidelines for the TAR process shall be developed by the Center for Quality Based Medicine.

SEISMIC RETROFIT

Retrofit Requirements

- The Seismic Retrofit requirements which hospitals are required to meet by 2008 and 2013 shall be delayed until 2020.
- This measure shall be double joined to the Patient Safety and Information Technology Act**.**